patient either responds favorably to an antidepressant or does not. Involving yet another care giver (a practice Dr Heikoff later decries) is hardly necessary and, once again, expensive.

Dementia is almost inexorably progressive, frustrating to treat and a terrible burden on the patient's family and no doubt on the patient. I have found that a caring family, a supportive nursing staff and the physician's willingness to advise are all that are necessary and useful. I would wonder if other primary care physicians feel the same.

ALAN PAUL ZELICOFF, MD
6100 Pan American Freeway NE, #365
Albuquerque, NM 87109

REFERENCE

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TO THE EDITOR: I have read, with interest, the article, "Features of Potentially Reversible Dementia in Elderly Outpatients" by Larson and co-workers.[1] I found the work done by the authors to be quite helpful in making the point that *all* patients with dementia, no matter their age or living status, deserve a comprehensive workup to look for potentially reversible conditions. My only exception to the authors' approach is that nowhere in the article is the value of computerized tomography (or magnetic resonance imaging) of the brain mentioned.

Computed tomography and magnetic resonance imaging of the brain are noninvasive, highly efficacious procedures in ruling out such reversible conditions as subdural hematoma, normal-pressure hydrocephalus and brain tumor. While a careful neurological history and examination are important, contemporary technology should not be ignored. True, computerized tomography and magnetic resonance imaging are relatively costly; but the long-term care often required for a patient with deteriorating mental status is far more costly, both in money and, more important, in emotional suffering by the patient and his or her family.

I think that *anyone*, young or old, who presents to a physician with organic dementia, deserves a good neurological evaluation; and that evaluation should include a computed tomographic or magnetic resonance scan of the brain.

ROBERT A. FINK, MD
Chief, Department of Surgery (Neurosurgery)
Herrick Hospital and Health Center
Berkeley, California
2500 Milvia St, Suite 222
Berkeley, CA 94704-2682

REFERENCE

1. Larson EB, Reifler BV, Sumi SM, et al: Features of potentially reversible dementia in elderly outpatients. West J Med 1986 Oct; 145:488-492

Side Effect of Captopril and Enalapril

TO THE EDITOR: I wish to focus *WJM* readers' attention on what appears to be a little-recognized side effect of captopril and enalapril—namely, bothersome coughing.

Reports of Cases

Two patients recently were noted with this problem in our general internal medicine practice.

The first patient, a 62-year-old woman, had been started on a regimen of enalapril maleate for the treatment of hypertension. The day following starting the drug (5 mg per day), a dry, ticklish cough developed that persisted and would awaken her in the middle of the night. This was bothersome enough to require narcotic medications prescribed by her local physician. I saw her after almost three months of this coughing problem. She had had no chest discomforts. Her lungs were clear. Pulmonary function studies showed forced vital capacity (FVC) of 2.4 (94%), and volume of gas forcefully expired in one second (FEV_1) of 2 (92%) before bronchodilator. These were unchanged after bronchodilator. The patient's medication was changed to captopril, 12.5 mg twice a day, and her coughing continued. The coughing did not clear until captopril therapy was also discontinued.

The second patient, a 76-year-old woman with hypertension, was started on a regimen of enalapril, 2.5 mg per day. Very shortly thereafter, she began noting a dry mouth and persistent ticklish cough without sputum production. This kept her awake at night. After four months of this, her medication was changed to captopril, 25 mg twice a day, in place of the enalapril. Her symptoms resolved completely and she was able to continue with captopril without difficulty.

Discussion

In the *Physicians' Desk Reference,* cough is mentioned as an uncommon side effect of enalapril. Dry mouth and dyspnea are listed as possible side effects of captopril but cough is not mentioned.

I believe that readers should be aware of coughing as a potential side effect of these medications. The two medications may or may not cross-react with each other in this regard. Awareness of this potential problem may help avoid lengthy diagnostic workups that may otherwise be unnecessary.

BENNIE J. ROSSETTO, MD
Kalispell Diagnostic Service
210 Sunny View Lane, Suite 204
Kalispell, MT 59901

Correction: Diagnostic Immunopathy

TO THE EDITOR: It has been brought to my attention that a manuscript mistake resulted in an error in Table 3 in the UCLA Specialty Conference in the July issue.[1] In that table (page 71) the marker studies for chronic leukemia appeared twice (redundant) and there is a mistake in the repeated part (11B4 should be corrected to B4).

P. A. CANCILLA, MD
Professor and Chairman
Department of Pathology
UCLA School of Medicine
Los Angeles, CA 90024

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1. Cancilla PA, Cochran AJ, Naeim F, et al: Diagnostic immunopathology (Specialty Conference). West J Med 1986 Jul; 145:65-73